

Food and Drug Administration Kansas City District Southwest Region 11630 West 80th Street Lenexa, Kansas 66214-3340

Telephone: (913) 752-2100

June 23, 2004

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

WARNING LETTER

Ref. KAN 2004-13

Roxianne G. Downing, C.E.O./Chairman Qualis, Inc. 4600 Park Avenue Des Moines, IA 50321-1237

Dear Ms. Downing:

On March 22 - April 2, 2004 a Food and Drug Administration (FDA) Investigator performed an inspection of your pharmaceutical manufacturing operation located at 4600 Park Avenue, Des Moines, Iowa 50321-1237. This inspection revealed serious deviations from the current Good Manufacturing Practice (cGMP) regulations, Title 21, Code of Federal Regulations, Parts 210 and 211 (21 CFR 210 and 211). These deviations cause your drug products to be adulterated within the meaning of Section 501(a)(2)(B) of the Federal Food, Drug, and Cosmetic Act (the Act). Section 501(a)(2)(B) of the Act requires that the methods used in, or the facilities or controls used for, the manufacture, processing, packing, and holding of drugs conform with cGMP to assure that such drugs meet the requirements of the Act as to safety, and have the identity and strength, and meet the quality and purity characteristics, which they purport or are represented to possess.

Deviations observed during the establishment inspection include, but are not limited to the following:

1. Failure to follow written procedures applicable to the function of the quality control unit [21 CFR 211.22(d)].

For example, your firm's SOP 15002.0 "Deviations" is not followed in that deviations from written procedures for drug product production are implemented without prior approval from the quality control unit. In addition, corrective actions to prevent recurrence of the deviations are not recorded as required by the same SOP.

2. Failure to thoroughly investigate failures of finished drug products or drug product components to meet established specifications [21 CFR 211.192].

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For example, there was no investigation to determine the reason for part of a lot of Sodium C14-16 Olefin becoming unusable in storage or of the impact of the use of the remaining material in drug products. In addition, there was no investigation or follow-up to determine the cause for low menthol assays, both upon initial testing and after reworking the product, in a lot of Therapeutic Pain Relieving Gel.

3. Written procedures for production and process control are inadequate to assure that the drug products have the identity, strength, quality, and purity they purport or are represented to possess [21 CFR 211.100(a)]

For example, during the manufacture of Anti-Fungal liquid, lot # 2H28B, a gallon, flat-bottomed tank, not qualified for use in this product's manufacturing process, was substituted for the gallon jacketed tanks specified in the procedure. Written procedures for production and process control are inadequate unless they include procedures that fully and successfully validate the performance of the drug manufacturing process. Qualification of equipment for use in the drug manufacturing process is a necessary component of this validation and is required by 21 CFR 211.63.

4. Components are not handled and stored in a manner to prevent contamination [21 CFR 211.80 (b)].

Examples include:

- a. Trisodium Phosphate, Lot #440106, was found opened while sitting on a cart with other raw materials, which were going to be used in manufacturing product on the following day.
- b. A box of Lot #420814, was found opened while sitting on a shelf in the raw materials storage area. This box had dried moisture stains with white, recrystallized salts on several areas of the box.
- c. Crasilk powder, lot #412190, was found partially opened on a shelf, with raw materials above and below this shelf, in the raw materials storage area, with a white powder observed on the top and around the opening into the box, which appeared to be a different type of material than was observed in the box of the actual raw material.
- d. (xanthan gum), Lot #431074, was observed to be opened in the raw materials storage area, and there was an oil-like stain on the box.
- e. Disodium EDTA Lot #440118, Part #010173, was observed to be

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opened in the raw materials storage area, with the box dented which could compromise container integrity.

5. Failure to perform operations within separate or defined areas or to use other control systems as are necessary to prevent contamination or mix-ups [21 CFR 211.42(c)].

For example, cans of a raw material labeled as "Benzyl Peroxide" being held pending sampling and testing were observed outside of the quarantine area on the same shelf as lots of the same material that had been released for use (21 CFR 211.42(c)(1)). In addition, barrels of rejected Calsoft AOS-40 were stored in the QA released raw materials storage area (21 CFR 211.42(c)(2)).

6. Failure to establish adequate acceptance criteria for sampling and testing to assure that batches of drug products meet each appropriate specification [21 CFR 211.165(d)].

For example, you have released and distributed into interstate commerce pharmaceuticals without establishing final release specifications. Your quality control unit has not done the requisite scientific testing and evaluation to establish final release criteria. The reasoning that you need to have an adequate number of batches is not valid since this practice has been in place for products with over 22 batches released over a four year period.

7. Failure to record the execution of production and process control functions, at the time of performance [21 CFR 211.100(b)].

For example, there were production records that were completed prior to completion of the production run. The Daily Production Ticket number 096323, for Lice Shampoo, Lot 4B19C, was signed off indicating that 1440 units, or one pallet load, were filled, when in fact the filling was still in process for the pallet of product.

It is our assessment that the deviations listed above and discussed with your firm's senior management are significant and are a reflection of weaknesses in one or more of the systems designed to control the manufacture of pharmaceuticals.

The above identification of violations is not intended to be an all-inclusive list of deficiencies at your facility. It is your responsibility to assure adherence with each requirement of the Act and its implementing regulations. Deviations from the cGMP regulations were noted on a Form FDA 483 that was issued to and discussed with Paul H. Strayer, Chief Operating Officer and Chief Financial Officer, during a close-out meeting held on the final day of the inspection. A copy of the Form FDA 483 is enclosed for your information.

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You should know that these violations might result in FDA taking regulatory action without further notice to you. These actions include, but are not limited to, seizure and/or injunction. Also, other federal agencies are informed about certain Warning Letters issued by FDA so they may consider this information when awarding government contracts.

Inspection at your facility also revealed a deviation from the medical device quality system regulations (Specifically, 21 CFR 820.22) that would cause two products, Personal Lubricant and Personal Lubricating Liquid, to be adulterated within the meaning of Section 501(h) of the Act. This deviation consists of a failure to implement a written procedure for quality audits for device products. Your firm claims to apply a written procedure requiring annual product reviews for drug products to your device products as well, but it was not followed for the two aforementioned products.

Please inform this office, in writing, within fifteen (15) working days of receiving this letter of the steps you are taking to correct these deviations. We acknowledge receipt of your response dated May 28, 2004 and are reviewing it. In your response to this correspondence please advise of additional actions and a detailed and specific timeline for the completion of your actions.

You should direct your reply to Ralph J. Gray, Compliance Officer, at the above address.

Sincerely,

Charles W. Sedgwick
District Director

Kansas City District

CREmbleto

Enclosure